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Legislative Audit Division

State of Montana

Report to the Legislature

March 2002

Limited Scope Performance Audit

Medicaid-Related Contracts, Waivers, and Administrative Processes

Department of Public Health and Human Services

This report provides an assessment of selected Medicaid-related management controls. Conclusions and recommendations address:

- **The need for centralized Medicaid oversight.**
- **Controls currently in place.**

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Members of the performance audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business and public administration, statistics, economics, accounting, logistics, computer science, and engineering.

Performance audits are performed at the request of the Legislative Audit Committee which is a bicameral and bipartisan standing committee of the Montana Legislature. The committee consists of six members of the Senate and six members of the House of Representatives.

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Legislative Audit Division

Limited Scope Performance Audit

Medicaid-Related Contracts, Waivers, and Administrative Processes

Department of Public Health and Human Services

Members of the audit staff involved in this audit were Tom Cooper, Angie Grove, and Kris Wilkinson.

LEGISLATIVE AUDIT DIVISION

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March 2002

The Legislative Audit Committee
of the Montana State Legislature:

We conducted a limited scope performance audit of specific areas of Medicaid administration at the Department of Public Health and Human Services. This audit was requested by the Legislative Finance Committee based on concerns relating to several Medicaid areas. The Legislative Audit Committee approved the audit as a high priority. Our report contains conclusions on department Medicaid administrative and fiscal controls. A written response from the department is included at the end of the report.

We appreciate the cooperation and assistance of department staff throughout the course of this audit.

Respectfully submitted,

Scott A. Seacat
Legislative Auditor

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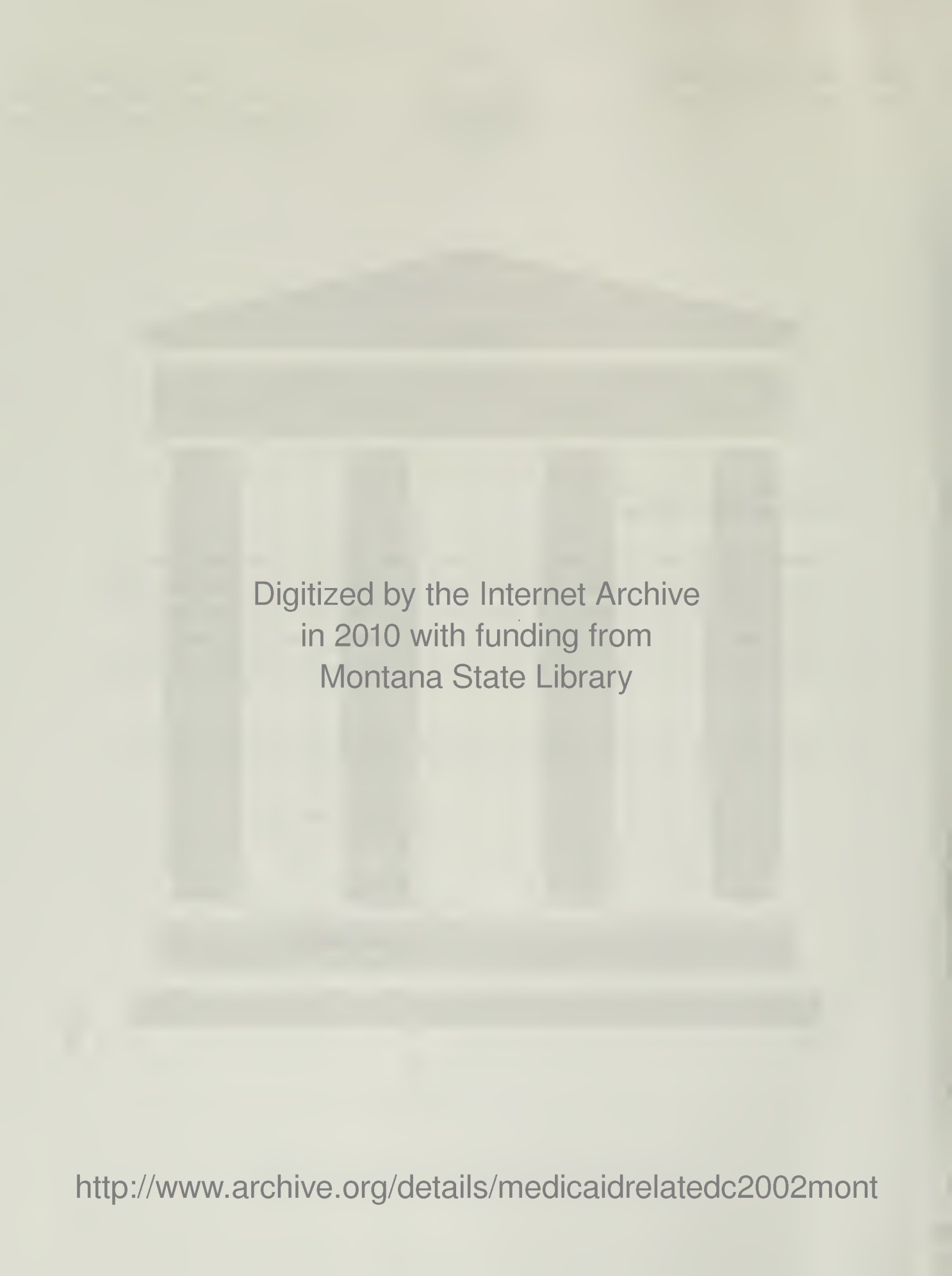
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Appointed and Administrative Officials

Department of Public Health and Human Services

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John Chappuis, Deputy Director
Carol Bondy, Internal Auditor
Marie Mathews, Audit Liaison

Division Administrators
Joe Mathews, Disability Services
Dan Anderson, Addictive and Mental Disorders
Maggie Bullock, Health Policy and Services
Hank Hudson, Human and Community Services
Mike Billings, Operations and Technology
Mary Dalton, Quality Assurance
Mike Hanshew, Senior and Long Term Care
Chuck Hunter, Child and Family Services
Mick Robinson, Fiscal Services

Introduction

At the request of the Legislative Finance Committee (LFC), the Legislative Audit Division conducted a limited scope performance audit of the management of Medicaid funds at the Department of Public Health and Human Services (DPHHS). Specifically, the LFC expressed concerns regarding:

- Awarding Medicaid contracts.
- Management of waivers
- Potential federal noncompliance with freedom of choice and availability of service requirements.

Audit Objectives

Our primary audit objective was to examine controls over divisions within DPHHS that administer the provision of Medicaid-funded services. DPHHS compliance with statutory requirements for Medicaid funding, waivers services, contracting controls, and Medicaid cost controls were reviewed. In each area, testing included a review of management processes, program procedures, and communications/coordination between divisions. We did not complete an assessment of all internal controls.

Scope Exclusions

There were two areas not included in our review. Due to the recent completion of the Legislative Audit Division's financial-compliance audit, we did not review specific internal controls previously tested. In that audit report, recommendations were made to strengthen Medicaid financial accountability. These recommendations addressed Medicaid accruals, indirect administrative costs, contract renewals, and federal cash management.

Another area not included in our audit objectives was the adequacy of individual Medicaid program services. Each program has different procedural requirements and performance measures. The department relies on a variety of means to determine provider service quality including licensure and certification, patient feedback, federal audits/reviews, the state surveillance utilization and review subsystem, independent service assessment, and prior authorization reviews.

Report Summary

Management of Montana Medicaid Funds

DPHHS is the Montana agency responsible for administering Medicaid funding. Eight divisions administer programs that use Medicaid funds. For fiscal year 2001, Montana's Medicaid budget was approximately $518 million. Medicaid related administrative costs for Montana in the fiscal year were over $20 million.

Additional Medicaid Controls Still Needed

Although the department is taking steps to strengthen management, we noted several examples where additional controls are needed to improve Medicaid coordination and decision-making. The following highlights these examples.

- No Central Oversight - Each division was assigned unique responsibilities, then encouraged to develop internal controls and processes to assure effectiveness. This approach focused on Medicaid services provided by the divisions, rather than management consistency and efficiencies. As a result, since reorganization, Medicaid operations evolved without centralized oversight. It has not been clear who was or should be responsible for overall Medicaid operational results.

- No Formal Budgeting and Tracking Methodology - Information on program activities and expenditures was available in some form in all divisions. The level of detail differed from division to division. For example, Senior and Long-term Care Division appropriations were tracked closely and shared with appropriate staff. We found this type of information is not available in other divisions. In some cases, Medicaid staff was not aware of their specific budget or appropriation for Medicaid services they managed.

- Provider Selection Procedures - There are four different approaches used to identify and select Medicaid services providers. Disabilities Services Division uses the state competitive bidding process to select providers. Addictive and Mental Disorders Division contracts with state approved providers reviewed by county governments to provide chemical dependency services under local county health plans. Senior and Long-term Care Division selects providers using a competitive bidding process for case management services and a fee-for-service process for other Medicaid services. Health Policy Services Division uses both the competitive process and fee-for-service process for provision of its Medicaid services. In the past, concerns have been raised with some divisions' practices regarding compliance with federal requirements intended to insure recipients can obtain services from any qualified provider.

- No Formal Method for Sharing Best Practices - There is no system for sharing best Medicaid practices between divisions. For example, all but one Medicaid related division, Disability Services Division, use a common contractor to make payments to service providers. Although consolidating provider payment services with one contractor in the other divisions has improved coordination of provider billing codes and system controls; the Disability Services Division continues to use a manual payment tracking system. The result is that the department has Medicaid provider services information on two systems with neither system providing comprehensive expenditure information for provider services.

The department has already taken the first step for improving controls. Additional resources in the form of a deputy director and an internal auditor have been committed to improve communication and coordination. During the audit we observed the initial efforts of a deputy director to strengthen planning and generally increase communications between Medicaid divisions.

We believe these additional resources can and should be an integral part of department efforts to improve Medicaid administrative controls. Specifically, because of the importance of Medicaid funding to Montana, the deputy director should be designated as the focal point for oversight and Medicaid budget and expenditures. The deputy director can assure consistent methodologies for budget tracking and provider selection. In addition, the deputy could establish procedures for sharing best management practices between divisions.

Federal Oversight of Medicaid Waivers

Following approval, the federal government routinely reviews state waiver activities to verify the original intent is met. We noted the divisions maintain documentation reflecting federal findings and recommendations as well as the state's responses. This documentation reflected communication and coordination with federal staff. During the 2000 federal review a concern about freedom of choice limitations was identified. The federal agency's identification of this concern did not disrupt services developed by the division, jeopardize the future funding availability, or impact division Medicaid administrative activities.

Waiver Controls Are in Place

Medicaid waiver controls at the department include defined procedures for coordinating services and assuring services are not duplicated. Communication and coordination between federal and state officials allows for issue resolution both during application processing and during the formal waiver review conducted by the federal government.

Medicaid Contract Controls

We identified two categories of Medicaid contracts: those for recipient benefits and those for administrative/program management duties. Contracts for recipient benefits include provider services, recipient screenings, utilization reviews, prior authorizations, and recipient transportation.

The department has designated contract monitors in each division to work with the various program managers when issuing contracts. We noted the monitors were familiar with department policy on contracting. Each monitor referred to a manual including the policy and the boilerplate language. Most had received training in procurement and contracting. All indicated they use department legal staff when questions relating to contracts arose. Contracts in each of the divisions were routed through the monitors for review prior to signature by the division administrator. Monitors also use a summary sheet to document the people involved in the contracting process. Department controls insure contractors agree to comply with federal criteria and provide standardized procedures for all divisions to follow. If followed, these controls provide assurance that federal funding availability should continue and should not impact department Medicaid administrative activities.

Management of Medicaid Administrative Expenditures

Medicaid administration costs are reimbursed by a federal match of 50 percent for the time incurred. While the majority of staff costs in the Medicaid divisions are reimbursed at either the current federal medical assistance percentage or the administrative 50/50 match rates, many administrative and financial staff performs duties for multiple federal programs. Administrative time must be accounted for to reflect expenditures to each program as outlined in the cost allocation plan.

Cost Allocation Plan Compliance

Montana's cost allocation plan was initially approved on July 1, 1999 and was re-certified for federal fiscal year 2000. A new version of the plan has been drafted to incorporate reporting and tracking capabilities of the new state accounting system. The federal oversight organization, Centers for Medicare and Medicaid, is aware of Montana's intention to revise the plan

In accordance with Office of Management and Budget circular A-87, the Centers for Medicare and Medicaid rely on state level audits to formally document compliance with cost allocation plan requirements. During the most recent financial-compliance audit of the department, audit staff tested methodologies to determine costs were allocated in accordance with the plan. Costs were allocated according to the current plan, the allocation was accurate, and the final allocation matched the billing amounts.

Fiscal Management Flexibility

Department staff was projecting costs for Medicaid benefits would exceed the budget amount for fiscal year 2002 and were evaluating alternatives to reduce expenditures. Section 53-6-101 (11), MCA, allows the department to set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of Medicaid benefits if available funds are not sufficient to provide assistance to all eligible people. We believe the intent to this language is to provide for flexibility in fiscal management of Medicaid benefit expenditures. We reviewed how mandatory versus optional benefit services affected cost control decision-making. We assumed department staff would initially consider reducing optional services to help reduce benefit expenditures.

Phrase "Optional Benefit Services" is Misleading

Federal criteria allow states to identify the list of optional benefit services currently included in Montana law. However, we found once the optional benefits are identified by the Legislature in the law, the optional benefits are effectively mandatory. Montana's legislature has not identified specific benefits for limitation from the optional list. Once an optional benefit is statutorily defined and available to Medicaid eligible recipients, legislators have expressed concern about reducing the level of care provided.

The department's ability to manage Medicaid benefits expenditures is limited because essentially all Medicaid services are considered to be mandatory for eligible recipients. Elimination of benefits services by department staff is not a realistic solution for cost control since the department's management is not initially responsible for making policy decisions impacting the level of care for eligible Medicaid recipients.

Chapter I - Introduction

Introduction

At the request of the Legislative Finance Committee (LFC), the Legislative Audit Division conducted a limited scope performance audit of the management of Medicaid funds at the Department of Public Health and Human Services (DPHHS). Specifically, the LFC expressed concerns regarding:

- Awarding Medicaid contracts.
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Audit Objectives

Our primary audit objective was to examine controls over divisions within DPHHS that administer the provision of Medicaid-funded services. DPHHS compliance with statutory requirements for Medicaid funding, waiver services, contracting controls, and Medicaid cost controls were reviewed. In each area, testing included a review of management processes, program procedures, and communication/coordination between divisions.

Audit Scope and Methodologies

Staff in eight DPHHS divisions were interviewed. These interviews focused on assessing management, contracting procedures, and cost allocation methodologies. We did not complete an assessment of all controls. Documentation was compiled on Medicaid:

- Management reports.
- Waiver documentation.
- Contract boilerplate language.
- Cost allocation and time reporting methodologies.
- Budget/expenditure tracking techniques.

Input from federal officials was also obtained. Federal and state laws, rules and regulations were examined. Legislative reports and budget information were reviewed. Federal and state websites for program administration criteria were accessed.

The Legislative Audit Division's Financial-Compliance audit of DPHHS (01-11) was released during our review. We used the results of the financial-compliance testing in our review.

Scope Exclusions

There were two areas not included in our review. Due to the recent completion of the Legislative Audit Division's Financial-Compliance audit, we did not review specific internal controls previously tested. In the audit report, recommendations were made to strengthen Medicaid financial accountability. These recommendations addressed Medicaid accruals, indirect administrative costs, contract renewals, and federal cash management.

Another area not included in the LFC request or our objectives was the adequacy of individual Medicaid program services. The department and federal government rely on a variety of means to determine provider service quality – licensure and certification, patient feedback, federal audits/reviews, state Surveillance Utilization and Review Subsystem (SURS), independent service assessment, prior authorization reviews, etc. In addition, each program has different procedural requirements and performance measures. Therefore, we excluded this area from our department-wide audit work. Program areas that came to our attention for further review are discussed below.

Future Studies and/or Audits

We identified several issues which were outside the scope of this audit, but may warrant further consideration. These issues included:

- Program Eligibility. This is an area that has not been reviewed independently for some time. Both regional and central office staff raised concerns. Some staff indicated eligibility determinations could be more efficiently performed in the central office. Other staff stated that all determinations (CHIP eligibility is determined centrally) should be done at the local level. Eligibility determinations relate to all DPHHS programs not just those funded by Medicaid. Potential issues include inconsistencies in policy interpretations and incorrect determinations.

- Medicaid Management Information System (MMIS) Contract. The contract with the MMIS provider is centrally managed by the Operations and Technology Division. However, most services are provided to the Health Policy and Services Division, which has the MMIS coordinator on staff. How coding changes and system enhancements are coordinated, prioritized, and managed was a concern raised by staff throughout the department.

- Pharmacy Program. A limited scope performance review of the Drug Delivery System for the Montana Medicaid Program (96P-12) was completed in September 1996. The report identified new department procedures for averting costs in the acquisition and delivery of drugs. How well these procedures are working is a current issue. According to department staff, pharmaceuticals are currently one of the fastest growing cost areas for Medicaid. Other states recently completed reviews in this area and identified potentially significant cost containment measures.

Report Organization

This report is organized into five chapters. Chapter II outlines background material for Medicaid administration in Montana. Chapter III discusses our testing and conclusions on specific Medicaid controls. Chapter IV addresses methods for managing Medicaid costs.

Chapter II - Background

Introduction

In Montana, the Department of Public Health and Human Services (DPHHS) is responsible for administering Medicaid funds. In 1995, the Legislature, through a reorganization of state government programs, established the department. As a result, eight divisions are now involved in the administration of Medicaid funds. Prior to 1995, most Montana Medicaid activities were centralized in one division in the Department of Social and Rehabilitation Services.

Federal Medicaid Oversight

In 1965, Congress passed legislation establishing Medicaid funding through Title XIX of the Social Security Act. Medicaid was established to provide funds for medical care for welfare recipients. Federal law mandates funding support for eligible groups such as persons over 65, pregnant women with low incomes, and people who are blind or disabled and meet poverty guidelines.

The federal agency responsible for state Medicaid oversight is the Centers for Medicare and Medicaid Services (CMS). In the past, this agency was called the Health Care Financing Administration. This agency is responsible for monitoring all state Medicaid-related activities, budgets, and proposed changes.

State Requirements

CMS requires states to outline how Medicaid funds will be used to support eligible recipients. To distribute funds to recipients, states must formulate their health care approach in a state plan submitted to CMS for approval. State plans define services available, scope of services, and establish eligibility standards. The plan is reviewed and can be amended annually. According to federal regulation, all state programs established with Medicaid funds have to meet fundamental criteria. These include:

- Recipients are free to choose any qualified provider.
- Service definitions must be established prior to use.
- The quality of services must be comparable to other medical services available to the general public.
- Services must be available on a statewide basis.

- Recipient confidentiality must be assured.
- Payment is considered payment in full.
- Services should be effective but provided at less costly rate.

Montana Medicaid-Funded Services

There are over 7,000 service providers who serve Montana's Medicaid-eligible population. Service providers include physicians, public health departments, clinics/hospitals, and private non-profit organizations. Either by contract or provider agreement, service providers agree to comply with Medicaid requirements and accept designated billing practices and rates. Medicaid funds are generally not paid to recipients; payments are made directly to service providers.

Medicaid Eligibility

There are two types of eligibles for Medicaid-funded services. The first is "categorical." This is an individual or couple who meets all nonfinancial eligibility criteria and whose income does not exceed categorically needy limits (blind, aged, FAIM, Social Security Act disabled).

The second type of eligible is "medically needy." This is an individual or couple otherwise eligible for Medicaid-funded services, but the income (and resources) level exceeds the limits allowed for categorically eligible. For medically needy, the individual or couple personally incurs an amount for medical expenditures before Medicaid coverage begins.

In calendar year 2001, there was an average of approximately 83,000 individuals of all ages per month eligible for Medicaid-funded services in Montana. In the past five years, the number of eligibles ages 18 and over has remained constant. There was an average of 34,850 in 1997, compared to 34,920 in 2001. The number of children eligible per month has increased from 37,496 in 1997 to 48,380 in 2001. About 22,000 people per month have eligibility but do not use services.

Medicaid Expenditure Categories

State expenditures for Medicaid benefits to recipients are reimbursed at prescribed federal medical assistance participation rates. Annually, the federal government calculates a new participation rate for each state. The formula is based on state population and is designed to reflect individual state needs and medical care capacity. This rate ranges from 40-90 percent. Based on this formula the federal government has generally paid approximately 70 percent of Medicaid benefit expenditures in Montana and the state provides the remaining 30 percent in matching funds.

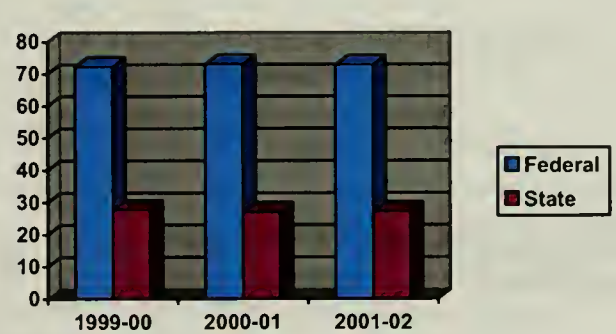
The second Medicaid expenditure category is for administrative expenses. Reimbursements for these expenditures are generally split evenly (50/50) between federal dollars and state funding support. Administrative expenditures relating to development of automated information systems are federally reimbursed at a rate of 75 percent.

Montana Expenditure Reimbursement Rates

For federal fiscal year 2000-01, the federal reimbursement rate for Medicaid benefit expenditures in Montana was 73.04 percent and the required percentage of matching state rate was 26.96 percent. For fiscal year 2001-02, the federal rate is 72.83 percent, leaving Montana's match at 27.17 percent. The following charts illustrate the percent of federal versus state funds for the last three fiscal years.

Figure 1

Medicaid Funding Rates



Source: Compiled by Legislative Audit Division

Other Issues Impacting Montana Medicaid Funding Needs

There are several issues that currently affect or will affect the demand for Medicaid funds in the future. These issues are likely to affect total Medicaid expenditures.

- Baby boomers versus depression-era elderly. As the number of depression-era elderly declines, there is less demand for senior care. Since senior care is the largest expenditure for Medicaid spending, the result is some short-term lowering of expenditures. This trend could ultimately impact provider availability in rural Montana. At some point, as users decline in numbers, nursing care facilities and other providers may struggle to stay in business to support minimum populations. In the not too distant future, the baby boomer population will begin to need the senior care services (a likely significant increase). The 2000 census shows Montana's population is aging. Since 1990, the number of residents over age 65 increased by 15 percent. The number of residents over age 45 increased over 47 percent. How to maintain capabilities in the interim presents a difficult problem.

- Health-care worker availability. An on-going problem for many Montana rural communities is the availability of skilled health care workers. According to department officials, the turnover rate for nursing home attendants is high. Similarly, as the state tries to develop more and more community-based services, the availability of skilled providers impacts (slows) the process.

- Complexity/cost of care. Improvement in medical care has resulted in people living longer. As a result, the kinds of medical conditions experienced by the elderly now are more complex than in previous generations. In addition, according to the U.S. Department of Labor, medical inflation is increasing at a rate higher than overall inflation. More complex medical care and a higher inflation rate result in higher costs.

While the department cannot influence the outcome of these issues, recognition of their impact will affect future program direction and management.

Management of Montana Medicaid Funds

DPHHS is the Montana agency responsible for administering Medicaid funding. As mentioned earlier, eight DPHHS divisions administer programs that use Medicaid funds. For FY 2000-01, Montana's Medicaid budget was approximately $518 million.

Medicaid-related administrative costs for Montana in fiscal year 2000-01 were over $20 million. General Fund support for administrative expenditures was approximately $7.2 million and State Special Revenue monies accounted for approximately $1.7 million.

The following table shows the divisions and the portion of Medicaid expenditures projected for administration and benefits in FY 2000-01 for each division:

Table 1

DPHHS Division Medicaid Expenditures
Fiscal Year 2000-01

DPHHS Divisions	Admin Expenditures	Benefit Expenditures.	Total Expenditures
Addictive and Mental Disorders (AMDD)	$ 2,394,691	$ 71,346,636	$ 73,741,327
Disability Services (DSD)	$ 1,340,846	$ 38,136,698	$ 39,477,544
Health Policy and Services (HPSD)	$ 6,178,360	$ 223,286,108	$ 229,464,468
Senior and Long Term Care (SLTCD)	$ 5,730,376	$ 149,872,025	$ 155,602,401
Child and Family Services (CFSD)	$ 38,217		$ 38,217
Human and Community Services (HCSD)	$ 7,356,126		$ 7,356,126
Operations and Technology (OTD)	$ 10,732,023		$ 10,732,023
Quality Assurance (QAD)	$ 1,676,363		$ 1,676,363
Total	$ 35,447,002	$ 482,641,467	$ 518,088,469

Source: Compiled by Legislative Audit Division from department records (unaudited).

Only four divisions, AMDD, DSD, HPSD, and SLTCD provide direct oversight of Medicaid benefits and services. CFSD qualifies youth for Medicaid covered services through its foster care program. However, the budget for the services provided is controlled by AMDD, DSD, HPSD, and SLTCD as the youth use services administered by these divisions. Statewide, HCSD staff determines recipients' financial eligibility to use the services administered by AMDD, DSD, HPSD, and SLTCD.

Two other divisions within DPHHS use Medicaid funding for administrative purposes. QAD, through its Audit and Compliance Bureau, verifies Medicaid compliance for appropriate eligibility, services, and billing. OTD completes the cost allocation plan, manages operation of the electronic eligibility system and compiles budget/management information.

Controls Needed for Managing Medicaid Funds

States are not required to organize their operations based on federal funding sources. Funding sources, such as Medicaid, can be distributed throughout any organizational structure as long as federal rules and requirements are followed. Therefore, the current DPHHS structure de-centralized Medicaid funded services. This structure was intended to strengthen program control processes and improve client services.

Implementation of this structure resulted in administrative strengths and weaknesses. Strengths included more individual program controls and the ability to focus on the delivery of services. Medicaid managers have more opportunity to respond to recipient needs. Weaknesses occurred in establishing the corresponding changes needed in fiscal controls, which impact the administration of Medicaid funds. For example, when management of certain services was consolidated in a division, the related fiscal/budget responsibility was not always relocated. Therefore, staff in one division tracked expenditures or appropriations used by other divisions. The problems associated with fiscal controls have been raised in financial audits of the department. Financial audit recommendations have been directed at developing specific accounting controls to support organizational changes. To build on the results of the recent financial audit, we focused on overall controls for Medicaid administration.

Chapter III – Medicaid Administrative Controls

Introduction

Department of Public Health and Human Services (DPHHS) is a very large state agency, both in total funding (over $1 billion) and FTE levels (over 2,800). Size and complexity of the wide spectrum of programs and projects vary. Prior to department re-organization in 1995, DPHHS management analyzed alternative organizational structures. The primary focus was on designing a structure to support services based on meeting recipient needs rather than administrative processes. Medicaid funding was not the criteria used to organize operations. Instead, reporting structure was designed for specific service interaction, span of control for supervisors, and the need for interdisciplinary teams. For example, elderly services such as adult protective services, aging services, and nursing facility services were consolidated within one division and disability services were centralized in another division.

Steps Have Been Taken to Establish Controls

This new structure was intended to strengthen control processes and improve client services. Upon development of a suitable organizational structure, the next step was to appraise existing and potential managerial resources and compare to department needs. In the past year, a deputy director was hired to coordinate overall management activities and an internal auditor was hired. These positions should be key components for strengthening administrative controls. Department management indicated the internal auditor will be responsible for assisting divisions in developing coordinated standards and methodologies as well as measuring division compliance and performance against developed standards.

Division management activities were recently re-evaluated to assure the availability of adequate Medicaid fiscal resources. A Fiscal Services Division was created to provide centralized management of fiscal procedures. This division will oversee functions such as purchasing, cash management, filing, federal reports, and recording/reporting of receipts and expenditures. Additional resources were recently provided in the Addictive and Mental Disorders Division (AMDD) to address the division's fiscal workload.

Additional Controls Still Needed

Although the department is taking steps to strengthen management, we noted several examples where additional controls are needed to improve Medicaid coordination and decision-making. The following highlights these examples.

- No Centralized Oversight – Each DPHHS division was assigned unique responsibilities, then encouraged to develop internal controls and processes to assure effectiveness. This approach focused on Medicaid services provided by the divisions, rather than management consistency and efficiencies. As a result, since reorganization, Medicaid operations evolved without centralized oversight. It has not been clear who was or should be responsible for overall Medicaid operational results.

- No Formal Budgeting and Tracking Methodology – Information on program activities and expenditures was available in some form in all divisions. The level of detail differed from division to division. For example, Senior and Long Term Care Division (SLTCD) appropriations were tracked closely and shared with appropriate staff. We found this type of information is not available in other divisions. In some cases, Medicaid staff were not aware of their specific budget or appropriation for the Medicaid services they managed.

- Provider Selection Procedures – There are four different approaches used to identify and select Medicaid service providers. Disability Services Division (DSD) uses the state competitive bid process to select providers. AMDD contracts with state-approved providers reviewed by county governments to provide chemical dependency services under local county health plans. SLTCD selects providers' using a competitive bid process for case management services and a fee for service process for other Medicaid services. HPSD uses both the competitive process and fee for service process for provision of their Medicaid services. In the past, concerns have been raised with some divisions' practices regarding compliance with federal requirements intended to ensure recipients can obtain services from any qualified provider.

- No Formal Method For Sharing Best Practices – There is no system for sharing best Medicaid practices between the divisions. For example, all but one Medicaid division, DSD, use a common contractor to make payments to service providers. Although consolidating provider payment services with one contractor in the other divisions has improved coordination of provider billing codes and system controls; DSD continues to

use a manual payment tracking system. The result is DPHHS has Medicaid provider services information on two systems with neither system providing comprehensive expenditure information for provider services.

Controls Should be Strengthened

Since the 1995 reorganization, DPHHS has not committed resources to coordinate the wide range of Medicaid activities administered by the divisions. When processes or procedures were identified in one division that suggested the potential for noncompliance or indicated a need for improvement, the lack of formal communication and coordination channels typically meant awareness was limited to one division. This created inconsistencies between Medicaid-funded functions.

The department has already taken the first step to strengthen controls. Additional resources in the form of a deputy director and an internal auditor have been committed to improve communications and coordination. During the audit we observed the initial efforts of the deputy director to strengthen planning and generally increase communication between Medicaid divisions.

We believe these additional resources can and should be an integral part of department efforts to improve Medicaid administrative controls. Specifically, because of the importance of Medicaid funding to Montana, the deputy director should be designated as the focal point for oversight of Medicaid operation and expenditures. The deputy director can assure consistent methodologies for budget tracking and provider selection. In addition, the deputy could establish procedures for sharing best management practices between divisions.

Recommendation #1

We recommend DPHHS strengthen controls by designating the deputy director to be the focal point for oversight of Medicaid operations and funding.

Medicaid Waiver Controls

States can request a waiver to some of the federal Medicaid requirements to maximize available funding resources and improve

the provision of services. The Social Security Act allows three types of Medicaid waivers: a demonstration waiver, a freedom of choice waiver, and a home and community-based waiver.

Waivers are based on cost-effectiveness criteria. A Medicaid waiver must be approved by the federal oversight agency, Center for Medicare and Medicaid Services (CMS). Montana has four waivers: one freedom of choice waiver and three home and community-based waivers. The following sections outline the requirements of each waiver and Montana's related waiver operations.

- Section 1115, Demonstration Waiver. Allows testing of new policies and could include a population previously not eligible or a service not previously available. We noted the demonstration waiver is not used widely across the country. Only 17 states currently administer approved demonstration waivers. Montana is not one of them. Most waivers are related to establishment of managed care activities, usually with a set-billing rate for services provided. Currently, DPHHS is considering applying for a demonstration waiver.

- Section 1915(b), Freedom of Choice Waiver. Allows states to waive statewide delivery of services, comparability of services, and freedom of choice criteria. The Montana Passport to Health program utilizes a section 1915(b) waiver. This waiver was renewed in October 1999. The Montana Passport to Health program provides primary medical services through a managed care organization.

- Section 1915(c), Home and Community-based Waiver. Allows states to waive statewide delivery of services, comparability of services and community income and resource rules for medically needy. Currently, Montana has three section 1915(c) waivers:

    - Disability Services Division (DSD), Home and Community-based Services. This disabilities waiver provides intensive support for a wide range of services for mentally retarded/developmentally-disabled recipients in lieu of institutionalization. The most recent renewal of this waiver was effective in December 1998.

    - DSD, Community Supports. Community Supports provides a range of services to developmentally disabled, meeting the needs of recipients who could receive higher cost home and

community-based services or institutionalization if the Community Supports services were not provided. This waiver was approved by CMS in August 2001.

- Senior Long Term Care Division (SLTCD), Home and Community-based Services. This waiver provides a wide range of community-based services through case management for elderly and physically disabled recipients. The SLTCD waiver was renewed in September 2001.

Waivers Used to Increase Cost Effectiveness

DPHHS tracks waiver cost effectiveness and annually submits reports to CMS that include cost effectiveness information. The data compiled by department staff compares the cost of using traditional Medicaid services to costs resulting from the use of waiver services. For the most recent federal fiscal year reports submitted (FY 1999-00), the department projected cost savings from the use of optional services available because of the waivers. For example, DSD's home and community-based waiver report estimated over $33 million in actual costs compared to more than $113 million if traditional institutional services had been used. Similarly, the report for the Passport program projected savings in excess of $6.5 million each year for primary care because of the management approach allowed by the waiver.

Waiver Application Process

We verified ongoing coordination between division and federal staff during initial planning and preparation of waiver applications. Staff in all divisions was generally aware of the range of services allowed by waivers in other divisions. We examined the application format used for submitting the most recent section 1915(c) waiver-Community Supports. Although the application is extensive (in excess of 100 pages), the standardized format allows for a "filling in the blanks" approach. We noted application submission and approval for the community supports waiver was completed in approximately twelve months. This included an initial submission of an amendment under the existing home and community-based services waiver, followed by a decision to prepare a stand-alone Community Supports application. During the interim period, CMS allowed the division to apply the new waiver criteria under the existing waiver.

Federal Oversight of Medicaid Waivers

Following approval, CMS routinely reviews state waiver activities to verify the original intent is met. Division staff were aware of the CMS waiver review cycle and the results of recent reviews. We examined the findings of the two most recent federal reviews. CMS completed DSD's home and community-based services waiver review in April 2001. SLTCD's home and community-based services waiver review was completed in August 2001. We noted the divisions maintained documentation reflecting the CMS findings and recommendations as well as DPHHS responses. This documentation reflected communication and coordination with federal staff.

During the 2000 CMS review of the DSD waiver, a concern about freedom of choice limitations was identified. DSD indicated this concern would be addressed by developing a process where all qualified providers can provide Medicaid services. CMS indicated satisfaction with the department's proposal, while recognizing resolution was a long-term process (two to three years).

Conclusion: The federal agency's identification of a concern did not disrupt services developed by the division, jeopardize the future funding availability, or impact division Medicaid administrative activities.

Waiver Controls Are in Place

Medicaid waiver controls at DPHHS include defined procedures for coordinating services and assuring services are not duplicated. The process for preparing and submitting requests for waivers is outlined in federal criteria. The application format is available and used by department staff. Communication and coordination between federal and state officials allows for issue resolution both during application processing and during the formal waiver reviews conducted by CMS.

Conclusion: Process and procedural controls for Medicaid waivers are in place and use of these controls provides for communication and coordination in managing the waivers.

Medicaid Contract Controls

We identified two categories of Medicaid contracts: those for recipient benefits and those for administrative/program management duties. Contracts for recipient benefits include provider services, recipient screenings, utilization reviews, prior authorizations, and recipient transportation. Administrative contracts are for billing service providers, computer programming and cost allocation services. These contracts do not include other forms of provider agreements. Some of the contracts are issued on an annual basis; others are issued for a period of up to seven years.

Criteria for Medicaid Contracts

We examined the federal and state requirements relating to contracts using Medicaid funds. Federal regulations outline a number of procurement methods acceptable under Medicaid. Acceptable methods include competitive sealed bids, competitive negotiation, and noncompetitive negotiation. It is the state agency's responsibility to determine the appropriate procedure needed for the procurement of services.

In addition to following federal requirements, DPHHS must follow state contracting requirements when purchasing services. The Montana Procurement Act, Title 18, Part 4, MCA, defines services as the furnishing of labor, time or effort by a contractor. Contracting for certain services administered by DPHHS are specifically excluded from Montana's procurement laws. Competitive bidding is not required for professional services such as those received from a physician.

Department Controls Include Standardized Procedures and Training

Due to the exclusions in state law, DPHHS legal staff developed policy on standard contractual terms for purchase of human, professional, and certain other Medicaid services. Included in DPHHS policy are standard contractual provisions (boilerplate) relating to political and lobbying activities, federal debarment prohibitions, civil rights, and confidentiality of patient information. In addition, the language requires the contractor comply with applicable requirements of all other federal laws, executive orders, regulations, and policies governing the program.

The department designated contract monitors in each division to work with the various program managers when issuing contracts. During interviews, we noted the monitors were familiar with DPHHS policy on contracting. Each referred to a manual including the policy and the boilerplate language. Most had received training in procurement and contracting. All indicated they used DPHHS legal staff when questions relating to contracts arose. Contracts in each of the divisions were routed through the monitors for review prior to signature by the division administrator. Contract monitors also utilized a summary sheet to document the people involved in the contracting process. This process helped ensure appropriate review prior to contract finalization.

Conclusion: DPHHS controls ensure contractors agree to comply with federal criteria and provide standardized procedures for all divisions to follow. If followed, these controls provide assurance that federal funding availability should continue and should not impact department Medicaid administrative activities.

Chapter IV - Medicaid Cost Management

Introduction

Montana is required by federal regulation to establish a cost allocation plan to identify allowable federal fund expenditures. The cost allocation plan outlines methodologies for identifying, measuring, and allocating state agency expenditures incurred in support of all federal programs. As noted in Chapter II, the federal government provides Medicaid funds at different rates for benefit and administration expenditures. For Montana, federal Medicaid funding support to pay for benefits is available at approximately 70 percent of expenditures with the state providing the remaining 30 percent. Most administrative expenditures are funded 50/50 by federal and state monies. In the following sections, we discuss:

- Management of Medicaid Administrative Expenditures.
- Management of Medicaid Benefit Expenditures.

Management of Medicaid Administrative Expenditures

In the case of Medicaid, costs documented in support of program administration results in a federal match of 50 percent for the time incurred. While the majority of staff costs in the Medicaid divisions are reimbursed at either the current federal medical assistance percentage or the administrative 50/50 match rates, many administrative and financial staff perform duties for multiple federal programs. Administrative time must be accounted for to reflect expenditures to each program as outlined in the cost allocation plan.

Cost Allocation Plan Compliance

Montana's current cost allocation plan was initially approved on July 1, 1999 and was re-certified for federal fiscal year 1999-00. A new version of the plan has been drafted to incorporate the reporting and tracking capabilities of the new state accounting system. The federal oversight organization, Centers for Medicare and Medicaid (CMS), is aware of Montana's intention to revise the plan.

We noted the cost allocation plan identifies several methodologies for compiling administrative costs associated with federal programs. These include:

- Random Moment Time Study. Selects a random number of staff from a pre-determined list to determine specific federal program activities at the time of the contact.

- Task Profile Identifiers. Documentation of time using task profile identifiers on monthly activity reports. Information may be compiled from staff payroll time sheets.

- Recipient or Staff Counts. Use of recipient counts or staff program FTE numbers to distinguish a percent of time dedicated to a program.

We contacted federal officials to determine if Montana's methodologies were consistent with those of other states. These officials offered the following comments:

- Compared to other states, Montana's cost allocation plan is more detailed.

- The federal agency will not mandate the level of detail or the types of methodologies used; it is up to each state.

- Methodologies used by Montana are used by a majority of states.

In accordance with Office of Management and Budget (OMB) circular A-87, CMS relies on state-level audits to formally document compliance with cost allocation plan requirements. During the most recent Legislative Audit Division Financial–Compliance audit (#01-11) of the department, staff tested methodologies to determine costs were allocated in accordance with the plan. The auditors concluded costs were allocated according to the current plan, the allocation is accurate, and the final allocation matches the billing amounts.

Conclusion: Management of Medicaid Administrative Expenditures Meets Requirements. We noted the methodologies used by DPHHS for this allocation are neither time-consuming nor complex. Current methodologies are designed to identify costs in a wide range of federal programs and address Medicaid requirements.

Management of Medicaid Benefit Expenditures: Mandatory versus Optional Services

The majority of Montana Medicaid expenditures are for recipient benefits. We noted state law distinguishes between mandatory and optional Medicaid benefits. Federal regulations make certain benefit services mandatory for all states that elect to participate in Medicaid and receive federal funding. For Montana the list of **mandatory** benefits identified in section 53-6-101(2), MCA, includes:

- Inpatient and outpatient hospital.
- Physician.
- Nurse specialist.
- Ambulatory prenatal care.
- Targeted case management for pregnant women.
- Medical and surgical dental.
- Nursing facility care.
- Laboratory and x-ray.
- Early and periodic screening, diagnosis, and treatment.
- Federally-qualified/rural health centers.

Federal law also allows states to select additional areas for Medicaid coverage. Section 53-6-101(3), MCA, identifies the following **optional** benefit services in Montana:

- Dental.
- Remedial care.
- Private duty nursing services.
- Mental health center.
- Inpatient psychiatric hospital for under 21 years old.
- Prescribed drugs, dentures, prosthetic devices and eyeglasses.
- Clinical social worker.
- Physical therapy.
- Home health care.
- Professional counselors.
- Hospice care.
- Inpatient psychiatric in a residential treatment facility for under 21 years old.
- Case management for mentally ill.
- Other diagnostic, screening, preventive, rehabilitative, chiropractic and osteopathic services.

Section 53-6-101(12), MCA, allows for the provision of community-based services as an alternative to long-term care facility services. In Montana, a significant portion of community-based services are designated as optional services and are available as a result of approved federal waivers.

Montana Benefit Expenditures

We worked with department staff to identify expenditures for four consolidated categories of benefits outlined in Montana law:

- Mandatory services for adults.
- Mandatory services for children.
- Optional services for adults.
- Optional services established through waivers.

For Medicaid eligible children, federal requirements mandate screening services. When medical conditions are identified through the screening, regulations also require treatment. As a result, all Medicaid benefit expenditures for children are identified in a mandatory category.

In the following table, we identify Medicaid benefits expenditures for these four categories. In addition, the table shows expenditures by Medicaid eligibility categories also reflected in state statute. These include categorically needy and medically needy, described on page 6 (chapter II). In addition, statute identifies two other categories of eligible recipients. Individuals receiving financial assistance (Families Achieving Independence in Montana (FAIM) eligible) may receive both mandatory and optional services. Individuals eligible for Medicare may receive Medicaid payment for Medicare premiums and deductibles. We noted $286 million or 64 percent of total Montana Medicaid expenditures for fiscal year 1999-00 were in the mandatory categories and optional benefits amounted to $160 million.

Table 2

Mandatory vs. Optional Medicaid Benefit Expenditures
(Fiscal Year 1999-2000)

Services/MCA	Categorically Needy	FAIM Recipient	Medically Needy	Medicare Eligible	Total
Adult Mandatory Section 53-6-101(2)	$ 33,853,894	$ 60,397,475	$ 75,377,252	$ 620,697	$170,249,318
Children Mandatory Section 53-6-101(2)(g)	$ 66,903,485	$ 48,302,946	$ 783,229	$ 82,267	$116,071,927
Adult Optional Section 53-6-101 (3)	$ 7,797,351	$ 60,358,582	$ 41,855,634	$ 221,722	$110,233,289
DSD Waiver Optional Section 53-6-101(12)	$ 33,553,392	-	-	-	$ 33,553,392
SLTC Waiver Optional Section 53-6-101(12)	$ 8,803,809	-	$ 7,563,341	-	$ 16,367,150
Total	$150,911,931	$169,059,003	$125,579,456	$ 924,686	$446,475,076

Source: Compiled by the Legislative Audit Division from department records (unaudited).

Fiscal Management Flexibility

During the audit, department staff were projecting costs for Medicaid benefits would exceed the budgeted amount for the current fiscal year (FY 2002) and were evaluating alternatives to reduce expenditures. Section 53-6-101(11), MCA, allows the department to set priorities to limit, reduce, or otherwise curtail the amount, scope, or duration of the Medicaid benefits if available funds are not sufficient to provide assistance to all eligible people. We believe the intent of this language is to provide for flexibility in fiscal management of Medicaid benefits expenditures. We reviewed how mandatory versus optional benefit services affected cost control decision-making. We assumed department staff would initially consider reducing optional services to help reduce benefit expenditures.

Phrase "Optional Benefit Services" is Misleading

Federal criteria allow states to identify the list of optional benefit services currently included in Montana law. However, we found once the optional benefits are identified by the legislature in the law, the optional benefits are effectively mandatory. Montana's

legislature has not identified specific benefits for elimination from the optional list. Once an optional benefit is statutorily defined and available to Medicaid eligible recipients, legislators have expressed concern about reducing the level of care provided.

According to staff, experience from other states attempting to reduce "optional benefits" has resulted in cost shifting. For example, pharmaceutical prescription expenditures account for the highest costs on the optional benefits list. Other states found when optional prescription services are reduced, eligible recipients increase visits to hospital emergency rooms, where Medicaid prescription services are mandatory to meet recipient medical needs. When this shift in expenditures occurs, total Medicaid expenditures actually increased because of the higher drug costs in that setting.

Adjusting Provider Rates is the Primary Method for Controlling Expenditures

The department's number one funding priority in the 2003 biennium was for rate increases for Medicaid providers. This conflicts with their first alternative for controlling expenditures. DPHHS staff indicated adjusting provider service rates is the primary alternative for controlling Medicaid expenditures. By reducing rates for benefits, total expenditures in any service category can be reduced. One of the concerns with reducing provider rates is the impact on the number of participating providers. If rates are reduced too far, providers will no longer elect to provide the services to recipients. As a result, staff must also consider the number of providers in various locations and compare actual costs to Medicaid approved rates.

We examined a consultant's review of Idaho's Medicaid management which was prepared at the request of their state legislature. The Idaho report confirmed rate adjustment is the primary tool used for managing Medicaid costs. Further, department officials are limited in their ability to manage Medicaid expenditures by reducing or eliminating services. This report indicated 65 percent of Medicaid expenditures were for federally designated mandatory services. Another 25 percent of expenditures, although optional from a federal perspective were described as state mandatory. The report classified the remaining 10 percent of expenditures as

optional. The Idaho report identified two other alternatives for cost control. A state can put restrictions on the number of visits to a specific provider such as a dentist; or the state-controlled eligibility criteria can be modified. However, changing eligibility criteria has an impact similar to elimination of an optional service. Once a service is available and provided there is a reluctance to reduce those services. Therefore, the methods used for managing Montana's Medicaid expenditures appear to be similar to those in Idaho report.

Conclusion: The department's ability to manage Medicaid benefits expenditures is limited because essentially all Medicaid services are considered to be mandatory for eligible recipients. Elimination of benefits services by department staff is not a realistic solution for cost control since DPHHS management is not initially responsible for making policy decisions impacting the level of care for eligible Medicaid recipients.

Department Response

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

JUDY MARTZ
GOVERNOR

GAIL GRAY, Ed.D.
DIRECTOR

STATE OF MONTANA

RECEIVED
MAR 1 5 2002
LEGISLATIVE AUDIT DIV.

March 14, 2002

Mr. Scott A. Seacat
Legislative Auditor
Office of the Legislative Auditor
State Capitol, Room 160
Helena, Montana 59620-1705

Dear Mr. Seacat:

Thank you for providing the Department an opportunity to reply to your final report on the audit of Medicaid-Related Contracts, Waivers and Administrative process.

We **partially concur** with the recommendation. The department will be looking at the organizational structure to identify the best way to manage Medicaid activities. Until further review is completed, we cannot assure that the structure will include the deputy director as the focal point for programmatic activities.

We appreciate the effort that has gone into your examination of the functioning Medicaid program and would like to complement your staff on a very thorough audit and report.

Please contact me if you have questions.

Sincerely,

John T Clappare
For

Gail Gray
Director

Cc Mike Hanshew
Dan Anderson
Joe Mathews
Maggie Bullock
Marie Matthews
Ken Pekoc

"An Equal Opportunity Employer"